MDR Tracking Number: M5-04-2540-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-14-04.

The IRO reviewed level II established office visits, therapeutic exercises, manual therapy technique, neuromuscular re-education rendered from 11-05-03 through 01-12-04 that were denied based upon "U" and "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee. The respondent did not raise any other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-02-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97110 dates of service 05-02-03 through 09-30-03 (19 DOS) denied with denial code "F" (not according to treatment guidelines). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

CPT code 97250 dates of service 05-02-03 through 06-06-03 (14 DOS) denied with denial code "F" (not according to treatment guidelines). The carrier's EOBs indicate payment has been made. The representative for the requestor was contacted on 11-17-04 (___ at phone # 713-739-1984) and verification was made that no payment has been made. Reimbursement per the 1996 Medical Fee Guideline is recommended in the amount of $602.00 ($43.00 X 14 DOS).

CPT code 97265 dates of service 05-02-03 through 06-06-03 (14 DOS) denied with denial code "F" (not according to treatment guidelines). The carrier's EOBs indicate payment has been made. The representative for the requestor was contacted on 11-17-04 (___ at phone # 713-739-1984) and verification was made that no payment has been made. Reimbursement per the 1996 Medical Fee Guideline is recommended in the amount of $602.00 ($43.00 X 14 DOS).

CPT code 97112 dates of service 05-05-03 through 06-06-03 (13 DOS) and 09-22-03 through 09-30-03 (5 DOS) denied with denial code "F" (not according to treatment guidelines). The carrier's EOBs indicate payment has been made. The representative for the requestor was contacted on 11-17-04 (___ at phone # 713-739-1984) and verification was made that no payment has been made. Reimbursement for dates of service 05-05-03 through 06-06-03 is recommended per the 96 Medical Fee Guideline in the amount of $455.00 ($35.00 X 13 DOS). Reimbursement for dates of service 09-22-03 through 09-30-03 is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of $181.80 ($29.35 X 125% = $36.36 X 5 DOS).

CPT code 97140 dates of service 09-22-03 through 09-30-03 (5 DOS) denied with denial code "F" (not according to treatment guidelines). The carrier's EOBs indicate payment has been made. The representative for the requestor was contacted on 11-17-04 (___ at phone # 713-739-1984) and verification was made that no payment has been made. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of $169.50 ($27.12 X 125% = $33.90 X 5 DOS).

Review of CPT code 97112 (2 units) date of service 05-02-03 revealed that neither the requestor nor the respondent submitted a copy of the EOB. Since the carrier did not provide a valid basis for the denial of the service and the requestor submitted convincing evidence of carrier receipt of the request for EOB's in accordance with Rule 133.307(e)(2)(B) reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $70.00 ($35.00 X 2 units).

CPT code 99213 dates of service 05-02-03 through 06-06-03 (14 DOS) denied with denial code "F" (not according to treatment guidelines). Review of information submitted by the requestor revealed that the services provided were within treatment guidelines. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $672.00 ($48.00 X 14 DOS).

CPT code 99212 dates of service 09-22-03 through 10-17-03 (13 DOS) denied with denial code "F",217 (the value of this procedure is included in the value of another procedure performed on this date). The carrier did not specify what CPT code 99212 was included in per Rule 134.202(a)(4). Reimbursement per the Medical Fee Guideline effective 08-01-03 is $46.41 ($37.13 X 125%) per date of service. However, the requestor billed $45.41 per date of service. Reimbursement is recommended in the amount of $590.33 ($45.41 X 13 DOS).

CPT code 97110 dates of service 10-01-03 through 12-19-03 denied with denial code "F" (reduced according to fee guideline). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

CPT code 97140 (56 units) dates of service 10-01-03 through 12-19-03 (28 DOS) denied with denial code "N,241" (not documented). The requestor submitted information to meet documentation criteria. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of $1,898.40 ($27.12 X 125% = $33.90 X 56 units).

CPT code 97112 dates of service 10-01-03 through 12-19-03 (28 DOS) denied with denial code N,241" (not documented). The requestor submitted information to meet documentation criteria. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of $1,027.32 ($29.35 X 125% = $36.69 X 28 DOS).

CPT code 99212 dates of service 10-20-03 through 11-03-03 (7 DOS) denied with denial code N,241" (not documented). The requestor submitted information to meet documentation criteria. Reimbursement per the Medical Fee Guideline effective 08-01-03 is $324.87 ($37.13 X 125% = $46.41 X 7 DOS). However, the requestor billed $45.41 for each date of service. Reimbursement is recommended in the amount of $317.87 ($45.41 X 7 DOS).

This Findings and Decision is hereby issued this 18th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 05-02-03 through 12-19-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 18th day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-2540-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

June 2, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY
30-year-old male with a right wrist injury at work on ___. Chronic pain with "joint derangement" was the result. He has received extensive chronic pain management and numerous therapy sessions – as detailed in the medical records available – approximately three hundred pages were reviewed.

REQUESTED SERVICE(S)
Level II established patient office visits, therapeutic exercises, manual therapy technique, neuromuscular re-education for dates of service 11/5/03 through 1/12/04.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION

Long-standing unidisciplinary treatment of chronic pain and chronic pain syndrome is not supported by the current peer reviewed literature. Refer to Drs. JJP Patil and JC King pivotal work in this area.